

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/25/2011
NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification Survey and Abbreviated Survey were initiated on 01/18/11 and concluded on 01/25/11. Deficiencies were cited with the highest scope and severity being a "G". A Life Safety Survey was conducted on 01/18/11 with the highest scope and severity being "F". ARO #KY00015475 was substantiated with no deficient practice. ARO #KY00015649 was unsubstantiated with no deficient practice. ARO #KY00015803 was substantiated with the G-level deficient practice identified. A repeat deficiency was cited at F 465.	F 000	Ridgeway Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist. Ridgeway Nursing and Rehabilitation reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Ridgeway Nursing and Rehabilitation reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which		
F 221 SS-G	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to identify changes in risk factors related to restraint use (side rails) for one (1) of twenty (20) sampled residents (Resident #13). The facility failed to attempt to eliminate or reduce physical restraints for Resident #13. On 06/17/10, Resident #13 fell from the bed with the side rails raised. The facility failed to identify that Resident #13 was at risk for climbing over the side rails per the "Side Rail Assessment". Resident #13 sustained a second fall from the bed with side rails raised on 08/08/10. Resident #13 was hospitalized for surgical repair of a fractured right hip.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Heather O'Banion

TITLE

Executive Director

(X6) DATE

3/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the "Side Rail Assessment" policy revealed side rail assessments should be completed upon admission, quarterly with the Minimum Data Set (MDS) assessment, and with any significant change. Additionally, full side rails could be considered a restraint, and if they were assessed as a restraint, the side rails should be treated accordingly. The side rail assessments were completed with quarterly MDS assessments.</p> <p>Review of the clinical record revealed Resident #13 was admitted to the facility on 02/16/04 with diagnoses which included Dementia and Depression. Further review of the MDS revealed the facility assessed the resident to have both short and long-term memory deficits, and as being severely impaired in skills for daily decision making.</p> <p>Review of the "Restraint-Physical" policy, dated 01/09/02, revealed no information related to reassessing the use of a restraint after a resident had an incident (fall) which may be related to the use of restraints. Per the facility's policy, restraints were to be re-evaluated at least quarterly to determine their continued need. Additionally, the policy stated the facility should make every effort to eliminate the use of the restraint.</p> <p>Review of the clinical record revealed Resident #13 was admitted to the facility on 02/16/04 with diagnoses which included Dementia and Depression. Review of the quarterly Minimum Data Set assessments dated 05/08/10 revealed the facility assessed Resident #13's side rails to be restraints. Review of the "Side Rail</p>	F 221	<p>Ridgeway Nursing and Rehabilitation does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Ridgeway Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents. Ridgeway Nursing and Rehabilitation strives to provide the highest quality care while assuring the rights and safety of all residents.</p> <p>F221 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure the residents are free from any physical restraints improved for purpose of discipline or convenience.</p> <p>1. Resident #13's side rail assessment has been reviewed and updated. At this time there were no changes in her assessment from the time of survey. This assessment was reviewed on 02/17/11.</p>	02/18/11	

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F 221	<p>Continued From page 2</p> <p>Assessment", dated 04/30/10, revealed the facility assessed that there was no possibility the resident would climb over the side rails. Interview with RN #3/MDS Coordinator revealed when conducting a review of the side rails she would interview staff, review clinical records, and look at any incident reports that may have been completed.</p> <p>Review of Physician's Orders and the "Treatment Record" revealed Resident #13's side rails were initially ordered on 03/16/10. Further review revealed the Physician's order did not have a medical condition for the use of the side rails, nor did the Physician's orders identify which type of side rails were to be used. In interview, on 01/21/11 at 6:45 PM, RN #3/MDS nurse stated the Physician's order for side rails times two (2) meant the four side rails would be up. She explained this was due to the facility's beds usually had two (2) full side rails.</p> <p>Review of the "Comprehensive Care Plan" dated 05/12/10, revealed Resident #13's side rails were identified as a restraint. The facility's goal for the side rails was for the resident to be free from injury. Review of the care plan revealed it did not detail the type and/or the number of side rails that were to be used.</p> <p>Review of the "Nurse's Notes" and a "Resident Accident/Incident Report" dated 06/17/10, revealed Resident #13 was found sitting on the floor beside the bed. The facility assessed the resident and found no injuries. Per the incident report, the resident was getting in, or out of bed, and the two (2) long side rails were up. The incident report indicated the facility's recommendation/action taken included</p>	F 221	<p>2. The Director of Nursing reviewed all residents with side rail orders for accuracy of the assessments, and possible reduction. All restraints are reviewed weekly in the facility's quality of care meeting; this was done on 02/17/11. No other problems were identified and all residents were in the least restrictive device.</p> <p>3. As part of the weekly quality of care meeting the facility will review restraint assessments to ensure the least restrictive measure is being used. In addition, if a resident experiences a fall or accident the Director of Nursing will review the appropriate assessment for any changes within 72 hours of the incident. Inservice education was provided to all licensed staff (RN, LPN, and CNAs) by the Administrator on 02/04/11 related to orders and individualized care plans related to restraint usage.</p>		

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F 221	<p>Continued From page 3</p> <p>continuation of frequent visual checks, encourage resident not to stand/transfer without assistance, and the addition of a pressure pad alarm to the bed. Review of the "Comprehensive Care Plan" revised on 06/17/10, revealed the care plan included the interventions from the "Resident Accident/Incident Report".</p> <p>Interview, on 01/24/11 at 7:19 PM, with Registered Nurse (RN) #2 revealed she was on duty 06/17/10 when Resident #13 was found on the floor. The RN stated the resident had to have "squirmed" through the side rails in order to get out of bed.</p> <p>Interview, on 01/24/11 at 4:51 PM, with State Registered Nurse Aide (SRNA) #13 revealed he was on duty 06/17/10 when Resident #13 was found on the floor. Per the SRNA the side rails were up. The SRNA stated Resident #13 would slide to the foot of the bed and try to get out. He stated the nurses were aware of the resident's habit of sliding to the foot of the bed.</p> <p>In interview, on 01/24/11 at 5:49 PM, SRNA #7 was on duty when Resident #13 fell on 06/17/10. SRNA #7 stated the side rails were up when she entered the room to assist with the resident. The SRNA verified the resident would slide to the foot of the bed and attempt to get up. She stated the nurses were aware the residents attempts to get out of bed.</p> <p>Interview, on 01/24/11 at 5:28 PM, with SRNA #5 revealed Resident #13 tried to climb out of the bed prior to the fall on 06/17/10 and "still tries to climb out of the bed".</p> <p>Interview, on 01/25/11 at 3:50 PM, with RN</p>	F 221	<p>4. As part of the facility's ongoing quality assurance program the Director of Nursing will audit 10% of all restraint assessments monthly for six months to ensure accuracy. Weekly the facility will continue to monitor restraint usage and assessments during the quality of care meeting.</p>		

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F 221	<p>Continued From page 4</p> <p>#3/MDS Coordinator revealed after review of the incident report and the Nurse's Note, she did not see anything about the side rails; therefore she did not complete a "Side Rail Assessment" for the 06/17/10 fall. RN #3 stated she had completed the 06/12/10 fall follow-up assessment on Resident #13 after the fall on 06/12/10 and could see no reason to add any other interventions than those she had suggested; even though the documentation on the incident report detailed the resident was getting in and out of bed with side rails up.</p> <p>Interview, on 01/25/11 at 2:53 PM, with Licensed Practical Nurse (LPN) #1, who also completed "Side Rail Assessments", revealed based on her review of the incident report, dated 06/17/10, and the Nurse's Notes for the 06/17/10 fall, she would need to complete a more comprehensive review of the side rails to determine the need for their continued use.</p> <p>Further record review revealed no documented evidence that the facility re-assessed to determine whether Resident #13's continued use of the side rails was safe.</p> <p>Interview, on 01/25/11 at 3:55 PM, with the Vice President of Clinical Operations revealed based on the incident report and the Nurse's Note for the 06/17/10 fall, she would assume the resident had climbed out of the bed but would need additional information.</p> <p>Review of the Minimum Data Set assessments dated 07/30/10 revealed the facility assessed Resident #13's side rails as restraints.</p> <p>Review of the "Side Rail Assessment" dated</p>	F 221		

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F 221	<p>Continued From page 5</p> <p>07/30/10 revealed the facility continued to assess that there was no possibility that Resident #13 would climb over the side rails.</p> <p>Record review revealed these assessments were completed by RN #3/MDS Coordinator. Interview with RN #3/MDS Coordinator revealed when conducting a review of side rails she would interview staff, review clinical records and look at incident reports that may have been completed. However, further review of these assessments revealed no evidence RN #3/MDS Coordinator considered the 06/17/10 fall involving the side rails when completing the side rail assessment to determine the safety of this resident's continued use of side rails.</p> <p>Review of the "Nurse's Notes", dated 08/08/10 at 9:30 AM, revealed Resident #13 had been found lying on the floor and was assessed to have no injuries. Per the Note, the resident was found on the floor and the side rails were still up. At 9:30 AM, an assessment of Resident #13 revealed no apparent injury. Additional Notes timed at 12:00 PM and 12:30 PM revealed no discomfort was noted. Per the 1:30 PM entry Resident #13 was noted to have pain in the right lower extremity upon transfer to bed and was sent to the hospital for further evaluation. Review of the "Progress Note", dated 08/11/10, revealed the resident had undergone a Total Hip Arthroplasty (hip replacement) after a fracture to the right hip. Additionally, the Nurse's Notes detailed the incident report was faxed to the Physician. However, the facility was unable to provide documented evidence of the incident report, for this fall.</p> <p>Interview, on 01/24/11 at 4:41 PM, with RN #1</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>revealed she was on duty on 08/08/10, when the resident sustained a fall. The RN stated when she entered the resident's room the resident was lying on the floor. The RN stated the resident would have had to have climbed over the side rails or out the foot of the bed. The RN stated the 08/08/10 fall was the first time she was aware that Resident #13 had fallen getting out of bed.</p> <p>Interview, on 01/25/11 at 10:43 AM, with State Registered Nurse Aide (SRNA) #6 revealed Resident #13 was sitting on the floor when she entered the room on 08/08/10. The aide stated the side rails were up.</p> <p>Review of the Significant Change Minimum Data Set assessment dated 08/20/10 revealed the facility assessed Resident #13's side rails as restraints.</p> <p>Review of the "Resident Assessment Protocol Summary" (RAPS) dated 08/26/10, revealed the facility assessed Resident #13 to have a physical restraint and the use of an alarming seatbelt related to a history of falls from the wheelchair. The RAPS did not identify the resident's side rail usage as a restraint and did not detail any risk factors associated with the use of the side rails. Additionally, the RAPS detailed the resident had experienced a recent fall with hip fracture. However, the facility did not identify/address the risk factors related to the use of side rails regarding the resident's falls on 06/17/10 and 08/08/10.</p> <p>Review of the "Side Rail Assessment" for Resident #13 with an assessment date of 08/20/10 revealed the facility continued to assess the resident to have no possibility to climb over</p>	F 221		

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F 221	Continued From page 7 the side rails. There was no documented evidence the facility attempted to reduce or eliminate the use of the side rails from 03/15/10 through 01/24/11. Interviews, on 01/24/11 at 4:51 PM, 5:28 PM, and 6:49 PM, with SRNAs #5, #6, #7 and #13 revealed they were aware that Resident #13 would scoot to the foot of the bed and attempt to get up. They stated the nurses were aware Resident #13 would attempt to get out of bed. In interviews, on 01/24/11 at 4:41 PM and 7:18 PM and on 01/25/11 at 2:45 PM RN #1, RN #2, RN #3 and LPN #1 denied knowledge of Resident #13's attempt to get out of bed unassisted. Observation of Resident #13, on 01/21/11 at 11:00 AM, revealed the resident was lying on the bed with side rails in place. Observation, on 01/21/11 at 12:40 PM, revealed the resident was lying on the bed with three (3) half side rails in place. Two (2) side rails on the right and one (1) side rail on the left side. Observations, on 01/24/11 at 3:42 PM, revealed the resident was lying on the bed with three (3) half side rails in place. Two (2) side rails on the left and one (1) side rail on the right side. Observation, on 01/24/11 at 5:15 PM, revealed the resident lying on the bed with four (4) half side rails in place. Random observations, on 01/25/11 from 11:50 AM until 3:20 PM, revealed the resident was lying on the bed with four (4) half side rails in place.	F 221			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225	F225 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure that all alleged violations involving	02/05/11	

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F 225	<p>Continued From page 8</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect or</p>	F 225	<p>mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation are reported immediately. The incidents described in the statement of deficiencies all involved residents who were confused. The definition of abuse is "a willful intent". There was no willful intent on the part of any resident described in this statement of deficiencies.</p> <p>1. Resident #13 is now bedfast and confused to time, place, and person. Resident #9's skin is intact and the skin tear healed without complications.</p> <p>Resident #10 continues to have a diagnosis of dementia with behavioral disturbances, with no further behavioral issues. Resident #10 receives psychiatric care routinely with medication adjustments. No further incidents have been noted.</p> <p>Resident #11 has a diagnosis of mental retardation. He receives psychiatric care through Pathways and has had numerous medication adjustments. No further incidents have been noted with resident 11.</p>		

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F 225	<p>Continued From page 9</p> <p>abuse including injuries of unknown origin, were reported immediately to the appropriate State Agency as evidenced by the facility failing to report three (3) different allegations of abuse involving five (5) of nineteen (19) sampled residents (Resident #7, #9, #10, #11, and #13). The findings include:</p> <p>Review of the facility's policy and procedures entitled "Abuse Reporting" revealed upon receiving reports of mistreatment, abuse, misappropriation of property, or neglect, the Administrator or Director of Nursing will immediately report the incident to the appropriate State Agencies. In the event the Administrator or the Director of Nursing is not available, the charge nurse will report the incident immediately.</p> <p>1. Review of the clinical record for Resident #13 revealed documentation of a resident to resident altercation involving Resident #13 and Resident #9. Review of the Nurses's notes, dated 06/17/10, revealed Resident #13 took a sharp pin and stuck it into Resident #9's leg causing a skin tear. Further review of the clinical record revealed the facility had assessed Resident #13 to have severe cognitive impairment. The facility developed a care plan for Resident #13 for disruptive behaviors related to dementia with a history of recurrent behaviors and intermittent threatening behaviors. The facility had assessed Resident #9 to have modified independence with daily decision making.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 01/21/11 at 4:30 PM, revealed Resident #13 took flowers out of the flower pot and stuck the metal end on one of the flowers into Resident #9's leg. Review of the facility's reports revealed</p>	F 225	<p>Resident #7 was not harmed and did not have any adverse effects related to the incident in question. This resident has a primary diagnosis of Alzheimer's.</p> <p>2. All staff (licensed and unlicensed) were inserviced on 02/04/11 by the Ombudsman and Administrator on abuse reporting protocol and the need to report immediately, and on Resident Rights. During the resident council (approximately 18 residents) were questioned related to potential abuse by other residents.</p> <p>3. The Administrator and Director of Nursing will review all incident reports (Monday through Friday) and shift reports to ensure any alleged violation of abuse, neglect, or misappropriation is reported immediately to all appropriate agencies, and a thorough investigation is conducted and residents are protected during the investigation. Per the facility policy any allegations of abuse will be reported immediately to the Administrator.</p>		

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 225	<p>Continued From page 10</p> <p>a Resident Accident/Incident Report was completed on 06/17/11 with a follow-up report completed on 06/17/11. However, there was no documented evidence the incident had been reported to the appropriate State Agencies.</p> <p>2. Review of the clinical record for Resident #10 revealed two resident to resident altercations involving Resident #10. On 06/16/10 review of a Resident Accident/Incident Report revealed Resident #10 was shouting and punching another resident. The report stated the other resident obtained scratches on the arm. The resident who was injured was not identified. On 07/09/10 review of the Resident Accident/Incident Report revealed Resident #10 was observed to hit another resident in the chest. The resident who was hit was not identified. The report indicated this resident was not injured. There was no documented evidence these two incidents had been reported to the appropriate State Agencies.</p> <p>Review of the clinical record revealed the facility had assessed Resident #10 to be moderately impaired in daily decision making. The resident had several diagnoses which included Dementia with Behavioral Disturbances.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 01/21/11 at 6:30 PM revealed she could not remember the other residents involved in the 06/16/10 or 07/09/10 incident.</p> <p>Interview with Registered Nurse (RN) #1 on 01/21/11 at 6:45 PM, revealed she was the nurse who had filled out the incident report on 07/09/10, but could not remember the other resident who was involved.</p>	F 225	<p>4. As part of the facility's ongoing quality assurance program the Administrator and Social Service Director will review any incident of resident to resident abuse to ensure it is reported to proper authorities. These incidents will be forwarded to the QA committee for review monthly. This will be ongoing.</p>		

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F 225	Continued From page 11 3. Review of the clinical record for Resident #11 revealed a resident to resident altercation. Review of the Nurse's Notes on 10/22/10 revealed Resident #11 was rubbing another resident on the back and was inappropriate with this resident. Interview with the Director of Nursing on 01/20/11 at 10:15 AM revealed Resident #11 was observed kissing Resident #7 on 10/22/10. Per interview and record review Resident #11 was placed on one to one supervision until the family arrived. The resident was taken home for the weekend, and sent for a psychological evaluation on 10/25/10. The resident returned to the facility on 10/25/10. There was no documented evidence the incident had been reported to the appropriate State Agencies. Review of the clinical record revealed Resident #11 had several diagnoses which included Mental Retardation (MR). The facility had developed a care plan for Resident #11 for socially inappropriate/disruptive behavior which included inappropriate sexual comments/behavior at times related to MR. Interview with the Vice President of Clinical Services on 01/21/11 at 9:50 PM, revealed she believed there was no intent for abuse related to the cognitive levels of residents involved and the incidents did not need to be reported to the State Agencies.	F 225			
F 281 SS=D	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure services provided or arranged by the facility meet professional standards of quality.	02/18/11	

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F 281	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to carry out physician's orders for one (1) of nineteen (19) sampled residents (Resident #7). Resident #7 had a physician's order to have a urinalysis on 08/05/10. The facility failed to obtain the test until 08/17/10.</p> <p>The findings include:</p> <p>Review of the clinical record revealed, a physician's order was obtained for a urinalysis to be completed on Resident #7 on 08/05/10. However, there was no documented evidence that the urinalysis was completed until 08/17/10. Review of the Nurse's Notes dated 08/06/10, revealed an attempt to obtain a urinalysis had been unsuccessful related to the resident being agitated. However, there was no documented evidence that other attempts to obtain the urinalysis were made.</p> <p>Review of the facility's "Lab Monitoring System" policy dated 11/02/07, revealed Step # 2 stated the admitting nurse or the nurse receiving the order would document the order on the laboratory calendar. Step #3 stated the medical record person would check the calendar and complete a lab requisition for the labs to be obtained. Step #4 indicated that a copy of the requisition would be maintained in a notebook at the nurse's station until the results were returned and reported to the physician.</p> <p>Interview with the Director of Nursing (DON) on 01/21/11 at 2:15 PM, revealed she was not</p>	F 281	<p>1. The urinalysis on Resident #7 was attempted on 08/05/10, however the resident refused. Resident #7 remains in the facility and has had additional urinalysis since 08/17/10, which were reviewed in accordance to physician's orders and obtained as ordered.</p> <p>2. All residents could potentially be affected. All ordered labs are monitored by the Director of Nursing on a daily basis to ensure there are none missed. This will be accomplished by reviewing the requisitions and lab calendar. This process will be ongoing.</p> <p>3. Labs ordered are placed on the lab calendar by the nurse receiving the order, daily medical records completes lab requisition for the next lab day. A copy of the requisition is maintained in a notebook at the nurse's station until lab results are returned and reported to the physician. The copy will be removed from the notebook by the nurse after he/she reports the results to the physician. If a requisition remains in the notebook then this</p>		

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F 281	Continued From page 13 employed during August, 2010, but was now the one responsible for tracking labs. She was unaware that the lab had not been obtained in a timely manner.	F 281	will flag the nurse that a lab has been missed. The notebook will be checked daily.		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide the necessary care and services for four (4) of nineteen (19) sampled residents when the Bowel Care Protocol was not implemented consistently (Residents #12, #18, #8, and #6). The findings include: Review of the facility's Bowel Care Protocol revealed the Nursing Assistant/Nursing would document every shift if a resident had a bowel movement. The policy stated if a resident had gone three (3) days without having adequate bowel elimination, the bowel protocol would be implemented. 1. Review of the Clinical Record revealed Resident #12 was admitted on 11/18/10 with diagnoses which included Diabetes, Hypertension, and status post Cerebrovascular	F 309	4. Weekly during the interdisciplinary care conference medical records will audit the charts of those residents scheduled for care plans to ensure labs have been obtained as ordered. A report will be forwarded to the Director of Nursing weekly. F309 It is and was on the day of survey the policy for Ridgeway Nursing and Rehabilitation to ensure each resident receives and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	02/18/11	

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F 309	<p>Continued From page 14</p> <p>Accident (Stroke). Review of the Physician Order dated 11/19/10 revealed the resident was to receive Lactulose, 20 Grams as needed for no bowel movement in three (3) days. Review of the Bowel Information Tracking Log for the month of December revealed Resident #12 did not have a bowel movement for five (5) days beginning December 1. Review of the Medication Administration Record (MAR) for the month of December revealed no Lactulose was administered, as ordered, during the five (5) day period.</p> <p>2. Review of the Clinical Record revealed Resident #18 was admitted on 06/23/09 with diagnoses which included Confusion, Diabetes, and Status Post Cerebrovascular Accident. Review of the Physician's Order, dated 06/23/09 and renewed monthly, revealed Resident #18 was to receive Lactulose, 10 Grams, every three days as needed for constipation. Review of the Bowel Information Tracking Log for September 2010 revealed Resident #18 had no bowel movement for the four (4) day period between September 14 and September 17 (four days) and September 25 through September 30 (six days). Continued review of the Bowel Information Tracking Logs revealed Resident #18 had no documented evidence of a bowel movement between October 2 and October 5 (four days), November 19 and November 22 (four days), and December 23 and 28 (six days). Review of the MAR for the months of September, October, November and December of 2010 revealed no Lactulose was given, as ordered, during these periods.</p> <p>Review of Resident #18's Comprehensive Plan of Care, developed on 07/12/09, revealed the facility had assessed the resident for the potential for</p>	F 309	<p>1. Resident #12 has been discharged to home.</p> <p>Resident #18 remains in the facility and is being monitored closely due to his diagnosis of constipation and diagnosis of volume depletion. Resident #8 remains in the facility. He has a terminal diagnosis with minimal P.O. intake. He is being monitored closely.</p> <p>Resident #6 remains in the facility. She requires frequent narcotics related to a fracture. She is being monitored closely.</p> <p>2. All nursing staff (licensed and unlicensed) were inserviced on the bowel care protocol on 01/27/11 by the Administrator and Director of Nursing.</p> <p>All resident bowel records will be reviewed daily by the night shift nurse to ensure the bowel protocol is implemented accurately. Daily a list of residents who require bowel intervention will be forwarded to the Director of Nursing.</p> <p>All resident bowel records have been reviewed by the Director of Nursing on 02/17/11.</p>		

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F 309	<p>Continued From page 15</p> <p>constipation related to the resident's decreased immobility and history of a Cardiovascular Accident (CVA). Interventions included to monitor and record bowel movements, to report if the resident had not had a bowel movement in three days, and to initiate bowel protocol if needed.</p> <p>3. Clinical Record review revealed Resident #8 was admitted on 04/03/08 with diagnoses which included Chronic Pain and Depression. Review of the Physician's Order, dated 10/22/10 and renewed monthly, revealed the resident was to receive Lactulose, 20 grams as needed for no bowel movement in three (3) days. Review of the Bowel Information Tracking Log for December 2010 revealed Resident #8 did not have a bowel movement for the four (4) day period between December 22 and December 25. Review of the MAR for December 2010 revealed no Lactulose was given, as ordered, during that period.</p> <p>Review of Resident #8's Comprehensive Plan of Care, revised on 11/09/10, revealed the facility had assessed the resident for the potential for constipation related to the resident's immobility, narcotic use, and chronic complaints of constipation. Interventions included to monitor and record bowel movements and to report if the resident had not had a bowel movement in three days; to initiate bowel protocol if needed; and, Lactulose as needed.</p> <p>4. Review of the Clinical Record revealed Resident #6 was admitted on 04/28/10 with diagnoses which included Dementia, Anxiety, and Depression. Review of the Bowel Information Tracking Log for December 2010 revealed no documented evidence the resident had a bowel movement for the six (6) day period between</p>	F 309	<p>3. Daily the night shift nurse will monitor the bowel log to ensure residents are having adequate elimination and follow up intervention. The day shift charge nurse will initiate necessary intervention. The bowel protocol will be implemented if the resident has not had a bowel movement in (3) three days. Day one a laxative will be administered, if no results day two a fleets enema will be administered, if no results day three a soap suds enema will be administered. The Director of Nursing will receive a list (Monday through Friday) and charge nurse (Saturday/Sunday) of those residents who require assistance with bowel elimination.</p> <p>4. As a part of the facility's ongoing quality assurance program the Director of Nursing or assessment nurse will audit 10% of all bowel elimination records daily (Monday through Friday) to ensure the above process is being completed. This process will be ongoing.</p>		

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F 309	Continued From page 16 December 21 and December 27. Review of the Physician's Order, dated 09/22/10 and renewed monthly, revealed Resident 36 was to receive Lactulose, 20 Grams every three (3) days as needed if no bowel movement. Review of the Mar for December 2010 revealed no Lactulose was given, as ordered, during the period. Interview with Certified Nursing Assistant (CNA) #13 on 01/21/11 at 1:50 PM revealed the CNAs were responsible for filling out the bowel log, on every resident, every shift. She stated the log was given to the nurse every day. Interview with Certified Medication Technician #1 on 01/21/11 at 2:15 PM revealed the CNAs gave the bowel movement report to the nurse at the end of each shift. She stated the night nurse would give Lactulose, 20 grams if a resident had no bowel movement for three (3) days. Interview with the Administrator and the Director of Nursing on 01/21/11 revealed the bowel protocol had been reviewed; in-services education had been conducted with staff; and, monitoring was in place. Per interview this had been fully implemented by the middle of October. However, record review revealed interventions had not been implemented per the facility's protocol in November and/or December for Residents #6, #8, #12, and #18.	F 309			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and	02/18/11	

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F 323	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to identify environment risk and causal factors for falls related to side rails for one (1) of nineteen (19) sampled residents (Resident #13). On 08/17/10, Resident #13 fell from the bed with the side rails raised. The facility's fall investigation failed to identify side rails as a causal factor to the resident's fall, despite staff knowledge of this resident's attempts to get out of bed with the side rails raised. This failure prevented the facility from re-assessing the resident for continued safe use of side rails. Resident #13 had a second fall from the bed with side rails raised on 08/08/10, and was hospitalized for surgical repair of a fractured hip. The facility failed to identify causal factors of the two falls and failed to re-evaluate risk factors associated with climbing over side rails on 08/17/10 and on 08/08/10 when Resident #13 sustained a fractured right hip requiring Total Hip Arthroplasty (hip replacement).</p> <p>The findings include:</p> <p>Review of the "Falls Program" revealed incident reports would be reviewed by the Director of Nursing and a fall's assessment would be completed.</p> <p>Review of the "Side Rail Assessment" policy revealed side rail assessments should be completed upon admission, quarterly with the Minimum Data Set (MDS) assessment, and with</p>	F 323	<p>assistive devices to prevent accidents.</p> <ol style="list-style-type: none"> 1. Resident #13 remains in the facility. Her condition has changed significantly since her last fall. She is now bedfast and rarely responsive. Her restraint assessment remains unchanged. 2. All residents who have orders for side rail use have been reviewed for accuracy of their assessment and possible reduction, by the Director of Nursing and Administrator. This review was conducted on 02/17/11 3. Weekly during the interdisciplinary plan of care meeting the Director of Nursing and/or MDS Coordinator will review the side rail assessment for accuracy. If a resident who uses bilateral side rails experiences a fall within 72 hours of the incident the Director of Nursing will review the side rail assessment to ensure accuracy of the assessment. All accident reports and investigations are reviewed daily (Monday through Friday) by the Administrator and/or Director of Nursing to ensure a safe environment 	

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F 323	<p>Continued From page 18</p> <p>any significant change. Additionally, full side rails could be considered a restraint and if assessed as a restraint should be treated accordingly. The side rail assessments were completed with the quarterly MDS assessments.</p> <p>Review of the "Restraint-Physical" policy, dated 01/09/02, revealed no information related to reassessing the use of a restraint after a resident had an incident (fall) which may be related to the use of restraints. Per the facility's policy, restraints were to be re-evaluated at least quarterly to determine their continued need. Additionally, the policy stated the facility should make every effort to eliminate the use of the restraint.</p> <p>Review of the clinical record revealed Resident #13 was admitted to the facility on 02/16/04 with diagnoses which included Dementia and Depression. Review of the facility's Side Rail Assessment, dated 03/15/10, revealed the facility assessed Resident #13 as incapable of climbing over the side rails. Review of the 03/16/10 "Physician's Order Form" and "Treatment Record" revealed side rails were to be raised times two (2) for Resident #13's positioning and mobility. In interview, on 01/21/11 at 6:45 PM, RN #3/MDS nurse stated the Physician's order for side rails times two (2) meant the four side rails would be up. She explained this was due to the facility beds usually had two (2) full side rails. Review of the 04/30/10 Side Rail Assessment revealed the facility continued to assess Resident #13 to have no possibility to climb over the side rails. Per the quarterly Minimum Data Set (MDS) assessments dated 05/06/10 the facility assessed Resident #13's side rails as restraints.</p> <p>Review of the "Comprehensive Care Plan" dated</p>	F 323	<p>for the residents. A complete audit was conducted by the Administrator and Director of Maintenance on 02/17/11 to identify any safety hazards.</p> <p>4. As part of the facility's ongoing quality assurance program the Director of Nursing will audit 10% of all restraint assessments monthly to ensure accuracy. This audit will continue for six months. Monthly the Director of Maintenance will conduct an audit for safety hazards. This will be ongoing.</p>		

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 19</p> <p>05/12/10 revealed Resident #13's side rails were identified as a restraint. The facility's goal related to use of the side rails was for the resident to be free from injury. Additional review of the care plan for the problem "Routine Care Needs" revealed the side rails were to be up times two (2) with interventions which included: dated 05/14/08, the right side rail to be up, dated 05/12/10 seatbelt alarm.</p> <p>Review of the "Nurse's Notes" and a "Resident Accident/Incident Report" dated 06/17/10 revealed Resident #13 was found sitting on the floor beside the bed with two (2) long side rails in use. The facility assessed resident #13 as having no injuries. Per the incident report, the resident was getting in or out of bed. However, review of the incident report revealed no documented evidence that the facility identified the side rails as a casual factor in the resident's fall.</p> <p>Interview, on 01/24/11 at 7:19 PM, with Registered Nurse (RN) #2 revealed she was on duty 06/17/10 when Resident #13 was found on the floor. The RN stated the resident had to have "squirmed" through the side rails in order to get out of bed.</p> <p>Interview, on 01/24/11 at 4:51 PM, with State Registered Nurse Aide (SRNA) #13 revealed he was on duty 06/17/10 when Resident #13 was found on the floor. Per the SRNA the side rails were up. The SRNA stated Resident #13 would slide to the foot of the bed and try to get out. He stated the nurses were aware of the resident's habit of sliding to the foot of the bed.</p> <p>In interview, on 01/24/11 at 5:49 PM, SRNA #7 was on duty when Resident #13 fell on 06/17/10.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 323	<p>Continued From page 20</p> <p>SRNA #7 stated the side rails were up when she entered the room to assist with the resident. The SRNA verified the resident would slide to the foot of the bed and attempt to get up. She stated the nurses were aware the of the resident's attempts to get out of bed.</p> <p>Interview, on 01/24/11 at 5:28 PM, with SRNA #5 revealed Resident #13 tried to climb out of the bed prior to the fall on 06/17/10 and "still tries to climb out of the bed".</p> <p>Interview, on 01/25/11 at 3:50 PM, with RN#3/MDS nurse revealed, after reviewing the incident report and the Nurse's Note, she did not see anything about the side rails; therefore, she did not complete a "Side Rail Assessment" for the 06/17/10 fall. RN #3 stated she had completed the 06/17/10 fall follow-up assessment on Resident #13 and could see no reason to add any other interventions than those she had suggested which included continue visual checks of resident frequently, remind resident not to stand or transfer without assistance, and add a pressure pad alarm to the bed. RN #3/MDS nurse confirmed that she had not identified the side rails as a causal factor to the falls and therefore did not complete a reassessment of Resident#13 to determine if continued use of side rails was safe for this resident.</p> <p>Review of the "Comprehensive Care Plan" revealed the facility identified problems related to trauma, potential for injury related to falls, Psychotropic drug use, bowel and bladder incontinence, and falls on 06/17/10 which included the following interventions: dated 05/14/08 included the right side rail to be up; dated 05/12/10 seatbelt alarm; dated 06/17/10</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WYOMING ROAD #3B OWINGSVILLE, KY 40360		
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F 323	<p>Continued From page 21</p> <p>continue visual checks of resident frequently and remind resident not to stand or transfer without assistance, and, a pressure pad alarm to the bed.</p> <p>Interview, on 01/25/11 at 2:53 PM, with Licensed Practical Nurse (LPN) #1, who also completed "Side Rail Assessments", revealed based on her review of the incident report, dated 06/17/10, and the Nurse's Notes for the 06/17/10 fall, she would need to complete a more comprehensive review of the side rails to determine the need for their continued use.</p> <p>Interview, on 01/25/11 at 3:55 PM, with the Vice President of Clinical Operations revealed based on the incident report and the Nurse's Note for the 06/17/10 fall, she would assume the resident had climbed out of the bed but would need additional information.</p> <p>Review of the "Nurse's Notes", date 08/08/10 at 9:30 AM, revealed the facility staff found Resident #13 lying on the floor and assessed the resident as having no injuries. Interview, on 01/24/11 at 4:41 PM, with RN #1 revealed she was on duty on 08/08/10. The RN stated when she entered the resident's room the resident was lying on the floor. The RN stated the resident would have had to have climbed over the side rails or out the foot of the bed. The RN stated the 08/08/10 fall was the first time she was aware that Resident #13 had fallen getting out of bed. Interview, on 01/25/11 at 10:43 AM, with State Registered Nurse Aide (SRNA) #6 revealed Resident #13 was sitting on the floor when she entered the room on 08/08/10. The SRNA stated the side rails were up, as they always were when the resident was in bed. The facility was unable to provide documented evidence of the incident</p>	F 323			

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F 323	<p>Continued From page 22 report or investigation related to this fall.</p> <p>Further review of the Nurse's Note", dated 08/08/10 at 1:30 PM, revealed Resident #13 had pain in the right lower extremity upon transfer to bed and was sent to the hospital for further evaluation. Review of the hospital "Progress Note", dated 08/11/10, revealed Resident #13 had undergone a Total Hip Arthroplasty (hip replacement) after a fracture to the right hip.</p> <p>Review of the "Side Rail Assessment" form revealed the facility continued to assess Resident #13 as having no possibility that he/she climbed over the side rails on 08/20/10. Interview, on 01/25/11 at 3:50 PM, with RN#3/MDS nurse revealed when conducting a review of the side rails she would interview staff, review clinical records, and look at any incident reports that may have been completed. Interviews, on 01/24/11 at 4:51 PM, 5:28 PM, and 5:49 PM, with SRNAs #5, #9, and #7 revealed they were aware that Resident #13 would scoot to the foot of the bed and attempt to get out of bed, by sliding down to the foot of the bed. They stated the Nurses were aware Resident #13 would attempt to get out of bed. While interviews with facility staff identified they were aware of the resident's tendency to attempt to get out of bed while the side rails were raised, additional review of the "Side Rail Assessment" form revealed no evidence the facility re-evaluated Resident #13's side rails as a causal factor for the falls on 06/17/10 or on 08/08/10.</p> <p>Observation of Resident #13, on 01/21/11 at 11:00 AM, revealed the resident was lying on the bed with side rails in place. Observation, on 01/21/11 at 12:40 PM, revealed the resident was</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360	
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F 323	Continued From page 23 lying on the bed with three (3) half side rails in place. Two (2) side rails on the right and one (1) side rail on the left side. Observations, on 01/24/11 at 3:42 PM, revealed the resident was lying on the bed with three (3) half side rails in place. Two (2) side rails on the left and one (1) side rail on the right side. Observation, on 01/24/11 at 5:15 PM, revealed the resident lying on the bed with four (4) half side rails in place. Random observations, on 01/25/11 from 11:50 AM until 3:20 PM, revealed the resident was lying on the bed with four (4) half side rails in place.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure food was served at proper temperatures as evidenced by foods served at substandard temperatures. The findings include: Observation of food temperatures on 01/19/11 at 12:40 PM revealed temperatures of ninety (90) degrees Farenheit for broccoll, ninety-two (92) degrees Farenheit for stuffing with gravy, eighty-eight (88) degrees Farenheit for pork chops which were items served to residents receiving a regular diet for lunch.	F 364	F364 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to provide food prepared by method that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 1. The residents were no adversely affected by the food temperatures. 2. All dietary staff were inserviced on 02/04/11 by the Administrator on proper food temperatures. 3. A plate warmer was purchased On 01/14/11 to help maintain proper food temperatures. In addition the daily temperature logs will forwarded to the Administrator for review.	02/18/11

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F 364	Continued From page 24 Interview on 01/19/11 at 12:30 PM with the Dietary Manager revealed her goals for point of service temperatures for the residents were one hundred and fifteen (115) degrees Fahrenheit or greater for hot food items and less than forty-one (41) degrees for cold food items. Review of the facility's policy regarding point of service temperatures titled "Minimum Temperature at Point of Service to Resident," not dated, revealed vegetables should be at least between 115-125 degrees Fahrenheit, meat should be at least between 115-125 degrees Fahrenheit and casserole dishes (such as the stuffing with gravy) should be at least between 115-120 degrees Fahrenheit.	F 364	4. As part of the facility's ongoing quality assurance program the Dietary Manager will audit trays weekly at varying times to ensure proper temperatures of food. A report will be reviewed monthly by the QA committee of the above findings. This process will continue for 6 months.	
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to store, prepare, distribute and serve foods under sanitary conditions as evidenced by out-dated food items stored in the refrigerator, scoop handles turned in	F 371	F371 It is and was on the day of survey the policy for Ridgeway Nursing and Rehabilitation to store, prepare, distribute, and serve good under sanitary conditions. 1. The out of date food and personal drinks were immediately removed from the refrigerator. Scoop handles are now turned in one direction. Handles outward to prevent containing scoops when reaching for them. Food temperature logs have been re-implemented. This is being monitored daily by the Dietary Manager.	02/18/11

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F 371	<p>Continued From page 25</p> <p>multiple directions, staff soft drink stored in freezer and lack of temperature measuring on food items served to residents.</p> <p>The findings include:</p> <p>Observation on 01/18/11 at 2:50 PM revealed two (2) twenty-eight (28) ounce containers of sour cream with manufacturer's expiration dates of 01/02/11 for one container and 01/16/11 for the other.</p> <p>Interview with the Dietary Manager on 01/18/11 at 3:10 PM revealed the sour cream should have been used or discarded before or on the expiration date.</p> <p>Observation on 01/18/11 at 3:00 PM revealed a drawer in the island food preparation table containing scoops with the handles turned in multiple directions.</p> <p>Interview with the Dietary Manager on 01/18/11 at 3:00 PM revealed the scoops should be stored upside down and handles turned in one (1) direction to prevent sediment and hands from coming in contact with the food contact surface.</p> <p>Observation on 01/19/11 at 11:45 AM revealed Dietary Aide #8 was measuring temperature of food items to be served to residents on the lunch trayline. It was noted there were no temperatures taken on the pureed vegetables, the pureed stuffing, to determine if adequate temperatures were reached during the cooking and holding process. Coffee and these items were subsequently served to residents eating dinner at the facility.</p>	F 371	<p>2. All dietary staff were inserviced on 02/04/11 by the Administrator on the above issues.</p> <p>3. The Dietary Manager will daily (Monday through Friday) and the cook (Saturday and Sunday) will check food storage, utensil storage, and food temperature log for compliance.</p> <p>4. As part of the facility's ongoing quality assurance program dietary sanitation will be monitored monthly for the next six months by the Dietary Manager. Daily the Dietary Manager is auditing key areas for sanitation and reporting to the Administrator. Monthly the dietician will review sanitation and report to the Administrator. Included in this report is equipment sanitation, storage of utensils and food, etc. These assessments will be made part of the QA minutes.</p>	

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F 371	Continued From page 26 Interview with Dietary Aide #8 on 01/19/11 at 12:15 PM revealed she normally does take the temperatures of all food items before food and drinks are served to residents. She could not explain this instance.	F 371			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public as evidenced by cracked tiles on A Hall, the tile behind the bathtub in shower room on C Hall was cracked, broken metal hand rail in shower room C and broken handrail in the shower room. The findings include: Observation on 01/19/11 at 10:15 AM revealed cracked tiles in Shower Room on C Hall. There was a portion of a metal handle bar left hanging on wall in this same shower room. Also, a portion of a heavy plastic bar was left hanging in shower in shower room on Hallway C. Also, on the hallway going between the dining room and past the nurse's station had several cracked and warped tiles. Observations of hot and cold water temperatures in room A11 revealed the water was forty (40)	F 465	F465. It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. 1. The facility has obtained several bids to replace the cracked tiles in the hallway. These tiles have been replaced numerous times only to re-crack due to the unlevel concrete under the tile. To correct this floor permanently will require extensive renovation. A contract has been signed with Carroll Flooring on 02/18/11 which details an expected completion date of 04/29/11. The metal handle bar and plastic towel bar have been removed. It should be noted one central bath has been completely renovated and the bath on B/C hall is scheduled for repairs. The cracked tile in the shower room has been temporarily repaired. The plumber corrected the water temperature problems on 01/18/2011.	02/19/11	

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 465	Continued From page 27 degrees Fahrenheit. Interview on 01/19/11 at 3:45 PM with the resident from room A11 revealed he/she had been complaining about the water temperature for months. The resident stated, 'it didn't do much good with previous administration, but it was addressed with this one, pretty quickly'. Further interview revealed the maintenance man had been in to attempt to fix it, but he was unable to do so. Interview on 01/19/11 at 3:55 PM with the Maintenance Director, revealed he had attempted to resolve the situation, but had to call in a plumber. When interviewed related to the damaged tile, the Maintenance Director stated he has procured several estimates and was waiting for corporate to give approval. The Director stated he was afraid someone was going to get hurt on either the cracked or badly warped tiles near the nurse's station.	F 465	2. All maintenance requests are being monitored by the Administrator (Monday through Friday). On Saturday and Sunday the charge nurse will call the Maintenance Director for emergency repairs. 3. A maintenance request will be completed for any necessary repairs. Once the repair is completed it will be forwarded to the Administrator with a date repaired and initials of who repaired the problem. 4. As part of the facility's ongoing quality assurance program monthly maintenance will provide the Administrator with a report detailing any repairs which have not been completed and the estimated time of completion. In addition, monthly the maintenance supervisor will conduct an audit identifying any safety hazards of necessary repair.		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F520 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to maintain an effective quality assessment and assurance committee.	02/19/11	

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F 520	<p>Continued From page 28</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to develop and implement an appropriate plan of action to correct identified quality deficiencies. The facility was cited, in 2010, for cracked and uneven floor tiles throughout the building. During the current survey, the tiles had not been replaced as indicated on the Plan of Correction.</p> <p>The findings include:</p> <p>Observations during the survey revealed cracked and uneven tiles were present throughout the building, with the worst being near the nurses station. Review of the deficiencies from the 2010 Standard Survey revealed the facility was cited for the same damaged tiles. Review of the Plan of Correction revealed the facility alleged a compliance date of 06/28/2010 regarding replacement of the tiles.</p> <p>Interview with the Maintenance Director on 01/19/11 at 3:55 PM revealed he was waiting on corporate approval to repair the floors.</p>	F 520	<p>1. The facility has obtained several bids to replace the cracked tiles in the hallway. These tiles have been replaced numerous times only to re-crack due to the unlevel concrete under the tile. To correct this floor permanently will require extensive renovation. A contract has been signed with Carroll Flooring on 02/18/11 which details an expected completion date of 04/29/11. The metal handle bar and plastic towel bar have been removed. It should be noted one central bath has been completely renovated and the bath on B/C hall is scheduled for repairs. The cracked tile in the shower room has been temporarily repaired. The plumber corrected the water temperature problems on 01/18/2011.</p> <p>2. All department managers have been inserviced on the facility's quality assurance program.</p> <p>3. The Administrator will chair the Quality Assurance program. A calendar and meeting schedule has been developed for monthly meetings. Indicators have been reviewed for all departments.</p>		

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 520	Continued From page 29 Interview with the Vice President of Clinical Services on 01/21/10 at 9:10 PM revealed the tiles could not simply be replaced as the floor beneath them was uneven. She stated she was aware the project would be an extensive one. She further stated bids had been taken at the corporate level but a specific plan for the renovation had not yet been determined.	F 520	4. The Administrator will ensure all Quality Assurance activities are conducted in a manner that assures issues are brought forth and addressed timely. A quality assurance log has been made available to all staff so issues which are not addressed on the calendar of indicators can be addressed quickly.		

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360	
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 01/18/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain corridor doors, according to NFPA standards. The deficiency affected four (4) residents, and the potential to affect staff and visitors.	K 018	K018 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to assure doors close properly to resist smoke. 1. The door to rooms A6 and C3 have been adjusted to close properly. 2. All doors have been assessed to ensure proper closure. 3. Monthly as part of the maintenance rounds all doors will be checked to ensure proper closure. 4. As part of the facility's Quality Assurance program the Maintenance Director will check doors monthly to ensure proper door closure.	02/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Heather O'Banion

TITLE

Executive Director

(X6) DATE

3/17/11

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360
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K 018	Continued From page 1 The findings include: Observation on 01/18/2011 at 3:56 PM, revealed resident room A6, had a gap at the top right corner of the door. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 3:56 PM, with the Maintenance Director, revealed he had not identified the door as having a gap, before the Life Safety Code survey. Observation on 01/18/2011 at 4:00 PM, revealed a trash can was placed in front of resident room C3 door. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 4:00 PM, with the Maintenance Director, revealed the trash can should not have been placed in front of the door Reference: NFPA 101 (2000 edition) 19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 025	<p>Continued From page 2</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained, according to NFPA standards. The deficiency has the potential to affect sixty (60) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 01/18/2011 at 2:47 PM, revealed an eight (8) inch square hole in the smoke barrier between the A and B corridor. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 2:47 PM, with the Maintenance Director, revealed he had not had the opportunity to check the smoke barriers, since he took over the position of Maintenance Director in November of last year.</p> <p>Observation on 01/18/2011 at 2:58 PM, revealed a two (2) x four (4) hole in the smoke barrier for the B/C corridor. The facility had failed to follow the Plan of Correction for the last survey. The facility was cited in 2010 during the last survey for the same penetration in the smoke barrier of B/C.</p>	K 025	<p>K025 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure smoke barriers are maintained according to NFPA standards.</p> <ol style="list-style-type: none"> 1. The hole between A and B corridor in the smoke barrier has been repaired. The smoke barrier for B and C corridor has been repaired. 2. All smoke barriers have been checked for proper maintenance. 3. Anytime someone accesses the attic area maintenance will check to ensure that no smoke barriers have been affected. 4. As part of the facility's ongoing Quality Assurance program the Maintenance Director will check all smoke barriers at least quarterly. 	02/28/11

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K 025	Continued From page 3 The plan of correction for last year stated the facility would repair the penetration to the smoke barrier. Interview on 01/18/2011 at 2:58 PM, with the Maintenance Director, revealed he had not had the opportunity to check the smoke barriers, since he took over the position of Maintenance Director in November of last year. Interview on 01/18/2011 at 5:30 PM, with the Administrator, revealed she had no explanation as to why the Plan of Correction was not followed to fix the penetration in the smoke barrier for the B/C corridor. Reference: NFPA 101 (2000 edition) 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050			

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K 050	<p>Continued From page 4</p> <p>The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to conduct fire drills, according to NFPA standards.</p> <p>The findings include: Record review on 01/18/2011 at 5:00 PM, of the Fire Drills for the facility, revealed the 2nd and 3rd quarter drills for 2010 were missing. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 01/18/2011 at 5:00 PM, with the Maintenance Director, revealed he was unable to locate copies of the fire drills conducted during the 2nd and 3rd quarter of 2010.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals</p>	K 050	<p>K050 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to conduct fire drills according to NFPA Standards.</p> <ol style="list-style-type: none"> 1. A fire drill schedule has been developed and implemented. 2. All staff were inserviced on 02/04/11 of fire drill procedures by the Administrator and Director of Nursing. 3. Monthly the Maintenance Director will ensure at least one fire drill is conducted and recorded (on rotating shifts) of the drills. Copies will be sent to the Administrator. 4. As part of the facility's on-going Quality Assurance program all fire drills will be reviewed and a copy maintained by the Administrator. 	02/05/11	

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K 050	Continued From page 5 and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			
K 062 SS=0	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinklers were maintained, according to NFPA standards. The deficiency has the potential to affect thirty (30) residents, staff, and visitors. The findings include: Observation on 01/18/2011 at 3:00 PM, revealed three (3) sprinkler heads located in the attic area were covered with blown in insulation. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 3:00 PM, with the Maintenance Director, revealed he was unaware of the insulation on the three (3) sprinkler heads. Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the	K 062	K062 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure sprinklers are maintained according to NFPA standards. 1. The blown-in insulation was removed from the three attic sprinkler heads. 2. All sprinkler heads have been assessed and are in proper working condition. 3. Monthly as part of maintenance audit all sprinkler heads will be observed. 4. As part of the Quality Assurance program the above audits will be reviewed by the Administrator to ensure compliance.	02/09/11	

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K 062	Continued From page 6 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. NFPA 101 LIFE SAFETY CODE STANDARD	K 062			
K 072 SS=F	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect sixty (60) residents, staff, and visitors.	K 072	K072 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to maintain a means of egress. 1. The linen carts, medication carts, and lift were moved. 2. All items that are in the hallway are moved at least every 30 minutes when not in use. 3. Daily the Director of Nursing will monitor the hallway to ensure proper egress. Items that are not being used will be removed from the means of egress.	02/16/11	

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K 072	Continued From page 7 The findings include: Observation during the Life Safety Code Survey on 01/18/2011 between 2:20 PM and 3:30 PM, revealed one (1) medicine cart, one (1) patient lift, one (1) clean linen cart and one (1) patient records cart located in the A Wing Corridor. Further observation revealed one (1) clean linen cart parked in the B and C Corridor. The observation was confirmed with the Director of Maintenance. Interview on 01/18/2011 at 3:30 PM with facility staff, revealed the clean linen carts stay in the corridors at all times. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	4. As part of the facility's ongoing Quality Assurance program monthly a safety survey will be completed which addresses means of egress. This will be completed by the Maintenance Director.		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the emergency generator was maintained according to NFPA standards. This deficiency has the	K 144	K144 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to inspect generators weekly and exercise under load for 30 minutes per month. There was a change in Administration and Maintenance in November 2010. Several records were not able to be located after that date. 1. Generator logs are currently being maintained in an electronic format and manually.	02/16/11	

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K 144	Continued From page 8 potential to affect sixty (60) residents, staff and visitors. The findings include: Review of the emergency generator maintenance logs on 01/18/2011 at 5:06 PM, revealed the maintenance logs from 05/10/10 through 12/28/10 were missing. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 5:06 PM, with the Maintenance Director, revealed he could not find the missing logs for the emergency generator. Reference: NFPA 99 (1999 edition) 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	K 144	2. All generator checks and run logs will be checked monthly by the Administrator. 3. All generator checks and run logs will be checked monthly by the Administrator. 4. Monthly as part of the Quality Assurance the generator checks and logs will be reviewed by the Committee.		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure electrical wiring was according to NFPA standards. The deficiency affected ten (10) residents, staff and visitors. The findings include:	K 147	K147 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to ensure electrical wiring and equipment is in accordance with NFPA 70. 1. Extension cords have been removed from rooms where they were in permanent use. New outlets have been installed. The electrical panel has been labeled properly. 2. All extension cords have been removed at this time.	03/04/11	

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K 147	<p>Continued From page 9</p> <p>Observation on 01/18/2011 at 3:46 PM, revealed an extension cord being used to power a television in resident room A7. Further observation revealed the cord was affixed to the underside of the sink with nails and several fastening devices. During the Life Safety Code Survey, several more electrical cords were found in this manner. The rooms include but were not limited to A3, A5, A8, and C8. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 3:46 PM, with the Maintenance Director, revealed that he would remove the electrical cords in use.</p> <p>Observation on 01/18/2011 at 4:18 PM, revealed an electrical panel located in the Mechanical Room was not labeled properly. Interview on 01/18/2011 at 4:18 PM, with the Maintenance Director, revealed the electrical panel was not labeled properly.</p> <p>NFPA 70 400-8. 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces <p>NFPA 99, Chapter 3 Electrical Systems.</p> <p>3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the</p>	K 147	<p>3. Monthly as part of the Quality Assurance audit the Maintenance Director will audit all rooms for extension cord usage. The electrical panel box will be audited annually.</p> <p>4. The above mentioned audit will be reviewed monthly by the Quality Assurance committee.</p>		

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K 147	Continued From page 10 intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			